STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155041	A. BUILDING _____ B. WING _____	C 09/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST MANOR HEALTH CARE CENTER	**6440 W 34TH ST INDIANAPOLIS, IN 46224**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00156595.

Complaint IN00156595 Substantiated, no deficiencies related to the allegations are cited.

Survey dates: September 24, 25, 2014

Facility number: 000015
Provider number: 155041
AIM number: 100273750

Survey team:
Connie Landman RN-TC

Census bed type:
SNF: 19
SNF/NF: 87
Total: 106

Census payor type:
Medicare: 19
Medicaid: 67
Other: 20
Total: 106

Sample: 6

Northwest Manor Health Care Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00156595.

Quality Review 09/26/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE